TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Dr. Glenn J Bricken & Associates

Respondent Name
Metropolitan Transit Authority

MFDR Tracking Number
M4-17-1699-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 6, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The DWC treating physician referred the claimant to Glenn J. Bricken, PsyD for an impairment rating consult. The adjuster approved reasonable and necessary and did not indicate the pre-authorization was required."

Amount in Dispute: $1,610.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Starr Comprehensive Solutions maintains the position that as a repeat interview (90791), preauthorization was required in accordance with Rule 134.600(p)(7). In addition, code 90791, may be reported more than once for the patient when separate diagnostic evaluations are conducted with the patient and other informants. A review of the submitted report does not support a separate diagnostic evaluation with anyone else other than the claimant to support billing the 2 units of code 90791. Psychological testing (96101) required preauthorization in accordance with Rule 134.600(p)(7)."

Response Submitted by: Starr Comprehensive Solutions, Inc. P.O. Box 801464, Houston, TX 77280

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 29, 2016	90791 (X2) 96101 (X6)	$1,610.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.600 sets out the requirements for prior authorization.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - W3 – Additional reimbursement made on reconsideration
   - 151 – Payment adjusted because the payer deems the information submitted does not support this many services
   - 197 – Payment denied/reduced for absence of precertification/authorization
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time
   - 197 – Per Rule 134.600)p)(7). All psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or Division exempted return-to-work rehabilitation program, requires preauthorization. This is a repeat interview, 90791 was performed on 6/15/15 by a different provider

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The requestor is seeking reimbursement for professional medical services rendered on September 29, 2016 of $1,610.00

   The insurance carrier denied Codes 90791 – "Psychiatric diagnostic evaluation" and 96101 – "Psychological testing" with claim adjustment reason code 197 – "Payment denied/reduced for absence of precertification/authorization."

   28 Texas Administrative Code §134.600 (p)(7) states in pertinent part,

   > Non-emergency health care requiring preauthorization includes:
   >
   > (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program;

   Based on the review of the submitted documentation, insufficient evidence was found to support that the service in dispute was part of a preauthorized or division exempted return-to work rehabilitation program. Therefore, prior authorization was required.

   The Division finds the carrier's denial is supported as requirements of 28 Texas Administrative Code §134.600 (p)(7) was not met.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		February 28, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.